Short-Doyle / Medi-Cal
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2011 (Schedule to be Determined)

1. Update SD2 system to validate the ITWS account/organization through which the containing file was received corresponds to the Interchange Sender identified in the Interchange Control Header (ISA05 & ISA06). If they do not match, file will be rejected with a SNIP error.
2. Deny claims when the Submitting County Code and Claim Submitter's Identifier (Loop 2300 CLM01) is a duplicate. This is the county-specific unique identifier and will be compared to the submitting county code. Claim will be denied with Adjustment Reason Group Code: CO, Adjustment Reason Code: 18, Health Remark Code N418 (misrouted claim). This edit will be disabled in the Staging system which will allow counties to resubmit test claims multiple times if necessary without having to make modifications between test runs.
3. On an 837P claim, when the procedure code is Targeted Case Management (T1017), and the place of service is 21 (Inpatient Hospital) or 51 (Inpatient Psychiatric Facility), a discharge date [Loop 2300 DTP03 (*DTP*096*D8*20110303~*)] will be required and must be within 30 days of the date of service.
4. Claims with Claim Frequency Type Code (CLM05-03) 5 (Late Charge Only) will be accepted for adjudication in the 837 I.
5. HIPAA Code Set Update (EDIFECS EDI Standards - HIPAA External Code Lists v7.0.14/v6.6.38 Release Notes) 837P claims with Claim Frequency Type Codes 2, 3, or 4 will be rejected by HIPAA edits.

December 2011 (Planned SD2 Effective Date)

1. Claim approval for Healthy Family (without SED) and Medi-Cal dual-eligible aid code.

Late-November 2011 (Planned SD2 Effective Date)

1. Extend Delay Reason Code 3 usage from 9/30/11 to 6/30/2012.
2. Effective for claims submitted after 9/30/2011, when a claim for service filed by an MHP is denied due to an error in the claim or due to incomplete information, the MHP may submit one or more replacement claims no later than fifteen months after the month of service. If the original claim included a Delay Reason Code (DRC), resubmit the same DRC on the replacement claim.
3. Bifurcated Databases for ADP and DMH: System Improvement to reduce current Backlog of claims adjudication.
4. Discontinue 277U Process Until Further Notice: Temporary Suspension of 277U Transaction with the potential to help reduce the current Backlog of claims adjudication.

October 15, 2011 (SD2 Effective Date)

1. Data Archival of the Phase I claims (both DMH and ADP) that were submitted prior to 36 months into a separate database. All phase I claims submitted prior to 10/1/2008 will be archived.

September 22, 2011 (SD2 Effective Date)

Program Coding Optimization:
1. Enhanced improved indexing to speed look up processes.
2. Reduced redundancy in storage.
3. Reconfigure BizTalk rules to be more efficient.
4. Reconfigure SQL server for improved performance.

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August 22, 2011 (SD2 Effective Date)

1. Allow claims for Therapeutic Behavioral Services (H2019) to be directly billed to Medi-Cal (both Medi-Medi and Other Health Coverage COB exclusions). *(Note: Targeted Case Management Services (T1017) are currently Directly Billable service claims to Medi-Cal regardless of Medi-Medi or Other Health Coverage status.)*
2. DMH Statewide Maximum Allowance (SMA) Rates for Fiscal Year 11/12 were implemented per DMH Information Notice 11-08.
3. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) State General Fund (SGF) Reimbursement Rate for Fiscal Year 11/12 changed to 0% per AB 100.
4. Phase II Void and Replacement claims referencing Phase I Claim IDs as the Original Reference Number (REF02) will be Denied with a CO 129 Error.

May 20, 2011 (SD2 Effective Date)

1. Allow the use of DRC 3 through 9/30/11 for original claims. Denied DRC 3 claims may be replaced through the 97-day period after 9/30/11.

May 2, 2011 (SD2 Effective Date)

1. System fix for claims inappropriately denied with the error code CO A1, N480 [Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)].

April 5, 2011 (SD2 Effective Date)

1. Termination of G8437. Claims with procedure code G8437 and a date of service **after** December 31, 2010, will be rejected by the HIPAA edits.
2. HIPAA Code Set Update (EDIFECS EDI Standards - HIPAA External Code Lists v7.0.8 /v6.6.32 Release Notes)
3. System will not reject transaction sets for Coordination of Benefits (COB) balancing errors. Unbalanced COB information in a transaction set shall not cause any unit of EDI (transaction set, functional group, or interchange envelope/file) to be rejected. Claims with unbalanced COB will be denied with CO A1, N480 [Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)].
4. System will allow replacement claims with a delay reason code to be adjudicated for original claims that were denied for being late, and could not be replaced when the replacement claim was submitted more than 12 months after the month of service. This scenario of replacement claim was previously denied with a denial reason code of CO 129.

February 25, 2011 (SD2 Effective Date)

1. System fix for claims with the following procedure codes and modifiers being inappropriately denied.
   H2015:HE:HQ:59 -- H2015:HE:HQ:76 -- H2015:HE:HQ:77
   H2015:HE:SC:59 -- H2015:HE:SC:76 -- H2015:HE:SC:77
   H2010:HE:HQ:59 -- H2010:HE:HQ:76 -- H2010:HE:HQ:77
   H2010:HE:SC:59 -- H2010:HE:SC:76 -- H2010:HE:SC:77
2. Allow modifiers HQ (Community) and SC (Telephone) to be used with or without the following procedure codes: T1017, H0032, H2017, H2019, G8437, H2011, H0034
3. Allow the use of procedure code H0034 (Medication Training and Support) for billing the following medication support service, service activities directly to Medi-Cal. Allow use of DRC "3" for H0034 and any dates of service.
   - Obtaining informed consent
   - Instruction in the use, risks, and benefits of alternatives for medications
   - Plan development related to medication support services

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February 9, 2011 (SD2 Effective Date)

1. Correction to 1/25/2011 System Update - Due to a system logic issue with the taxonomy edit implemented January 25, 2011 (item 2.), certain DMH claims were incorrectly denied with the error CO-22-N192 (Medicare must be billed prior to the claim submission). This is the correction to the issue. (Action Item 232)

January 25, 2011 (SD2 Effective Date)

1. Reactivate Aid Code 4G.
2. Allow Mental Health Services (H2015) and Medication Support Services (H2010) as directly billable services to Medi-Cal when the provider taxonomy code prefix is not:
    - 103 (Psychologists)
    - 104 (Social Worker)
    - 207 (Physician)
    - 208 (Physician)
    - 363 (Nurse Practitioner / Physician Assistant)
    - 364 (Nurse Specialists)

    NOTES:
    - H2010 and H2015 services processed prior to April 1, 2011, will not be denied if the rendering provider taxonomy code is blank as long as the Provider Accept Assignment Code (Loop 2300 CLM07) is set to 'C.'
    - H2010 and H2015 services processed on or after April 1, 2011, will be denied if the rendering provider taxonomy code is blank, regardless of the Provider Accept Assignment Code.
    - It is acceptable to provide the taxonomy code on any claim regardless of the circumstances.

January 10, 2011 (SD2 Effective Date)

1. Make the 835 units of service negative for void (and related replacement) claims. (Action Item 210)
2. Return 835 responses for approved zero dollar claims. (Action Item 157)
3. Allow the use of DRC 3 through 6/30/11 for original claims. Denied DRC 3 claims may be replaced through the 97-day period after 6/30/11.
4. Allow the use of good cause delay reason code (DRC) "3" for Medication Support Services (H2010).
5. Enable Aid Code 4T. Deactivating Aid Codes 4G, 5X, 5Y, 0R, 0T, 53, 8Y, 81.
6. Allow the use of procedure code G8437 (documentation of clinician and patient involvement with the development of a care plan) for billing the following medication support service, service activities directly to Medi-Cal. Allow use of DRC "3" for G8437.
    - Obtaining informed consent.
    - Instruction in the use, risks, and benefits of alternatives for medications
    - Plan development related to medication support services

December 28, 2010 (SD2 Effective Date)

1. Update ARRA FMAP percentages (by date of service):
    a. 10/01/08 through 12/31/10: 61.59%
    b. 01/01/11 through 03/31/11: 58.77%
    c. 04/01/11 through 06/30/11: 56.88%
    d. 07/01/11 and on: 50.00%
2. Allow the use of good cause delay reason code (DRC) "3" for Mental Health Services (H2015).

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December 15, 2010 (SD2 Effective Date)

1. Allow procedure modifier "GT" on tele-psychiatry claims so that these Medicare billable services can be subsequently billed to SD/MC with "GT".
2. Allow the use of good cause delay reason code (DRC) "3" and repeat procedure modifiers for Rehabilitation Services (H2017).
3. Allow Plan Development (H0032) as a directly billable service to Medi-Cal. Allow DRC 3 with H0032.
4. Deny claims with zero dollar Line Item Charge Amount.
5. Make the HIPAA validation report ("SR file") available to counties in HTML format.

November 24, 2010 (SD2 Effective Date)

1. Enable Aid Codes 4H and 4L
2. Internal system updates.

November 12, 2010 (SD2 Effective Date)

1. Emergency fix for billing Outpatient Hospital Services (Mode 12 - General Hospital or Psychiatric Hospital taxonomies) by an MFT.
2. Allow the use of good cause delay reason code (DRC) "3" for Targeted Case Management (T1017). The use of DRC "3" expires for all Medi-Medi billing after April 30, 2011. Claims with DRC "3" after this date will be denied.
3. Specialty mental health services are directly billable to Medi-Cal when the procedure modifier indicates:
    - Telephone services (SC procedure modifier, any place of service)
    - Services in the community (HQ procedure modifier with place of service 99 - 'Other')
4. Update COB edit so that OHC = "F" (Medicare RISK HMO) is not considered Medicare coverage.

October 25, 2010 (SD2 Effective Date)

1. Allow outpatient billing on day of discharge from inpatient psychiatric hospital.

October 11, 2010 (SD2 Effective Date)

1. Mobile or School (03 or 15) place of service (Action Item 79A)
2. Marriage Family Therapist (MFT) rendering provider taxonomy code (106H00000X) (Action Item 79A)
3. H2017 - Rehabilitation Services (Action Item 79A)

August 26, 2010 (Companion Guide Update)

OHC – No Response After 90 Days (Action Item 121)
When billing to other health coverage is required, billing is initiated, and no response is received after 90 days, the claim may be submitted with COB information for the other health coverage that was billed as follows:

- Loop 2320 CAS segment with OA*A7 will indicate an over 90 day situation. The adjustment should be the amount of the claim. The adjudication date should be the 91st day after the OHC billing date.

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May 18, 2010 (SD2 Effective date)

The following services were made directly billable to Medi-Cal (see DMH Information Notice 10-11 for more information):

H2011 - Crisis Intervention
H2013 - Psychiatric Health Facility
H0018 - Crisis Residential Treatment Services
H0019 - Adult Residential Treatment Services
S9484 - Crisis Stabilization
H2012 - Day Treatment Intensive / Day Rehabilitation
H2019 - Therapeutic Behavioral Services
H0046 - Administrative Day Services

- Good cause delay reason code (DRC) "3" will allow counties to submit claims for dual eligible clients that are older than six months from the month of service but less than one year from the month of service. DRC "3" may be used for original or replacement Medi-Medi claims delayed due to implementation of new State edits for Medi-Medi billing. Medi-Medi replacement claims submitted due to the new edits will be exempt from the 97 day replacement rule.
- Original claims submitted over one year from the month of service will be denied.

June 30, 2009

Per, DMH Information Notice 09-09, Targeted Case Management (T1017) was made directly billable to Medi-Cal upon Short-Doyle 2 (SD2) system startup.